Attachment A

Violations and Deficiencies
Concord Retirement Center
License # HAL 013-028

1. G.S. 131D-21 Resident Rights (# 2 and #4) and 10A NCAC 13F.0909

31D-21(2) Declaration of residents' rights Each facility shall treat its residents in accordance with the provisions of this Article. Every resident shall have the following rights:

(2) To receive care and services which are adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations.
(4)To be free of mental and physical abuse, neglect, and exploitation.

The facility failed to assure that residents received care and services which were adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations and were free of mental and physical abuse, neglect, and exploitation. Based on interviews of facility staff, residents, and according to the Cabarrus County Department of Social Services, there had been allegations and reports of illegal drug use in the facility and the buying and selling of drugs by both staff and residents. Based on interviews with staff and residents on 7-27-05, two of five residents and one of eight staff interviewed stated they had observed staff and residents using alcohol or illegal substances at the facility. Interviews with six of eight staff indicated staff had heard of use of alcohol and illegal substances by other staff and residents over the past year. Interviews with a staff person indicated that one resident and one staff person had sold illegal substances to residents at the facility. The use of alcohol and illegal drugs by staff impairs judgment and performing tasks, which place residents' safety and welfare at imminent risk. Residents' underlying health and mental conditions combined with the use of alcohol and illegal substances place the residents' health, safety and welfare at imminent risk.

There was a complaint filed by an anonymous employee on 9/14/04 of illegal drugs being sold to and used by staff and residents. An investigation was conducted and the licensee (administrator-in-charge) was interviewed in person at the facility on 10/4/04 by the Adult Home Specialist of the Cabarrus County Department of Social Services regarding the allegations of drug use at the facility. The licensee stated she was not aware of any drug problems at the facility. The licensee was made aware during the interview of reports about drugs used and sold at the facility. The licensee admitted to knowing of a resident with a history of alcohol treatment. Drug testing was discussed and the licensee agreed to voluntarily schedule a drug test for employees. The drug testing was never conducted.

Based on documentation of a facility visit on 12/15/04 and an interview with a facility employee who stated they observed a resident rolling a marijuana cigarette in the facility. Staff also had observed two residents smoking crack from a pipe in their room. The employee stated that the Licensee ignored the activities happening at the facility.

Another report on 2/9/05 from anonymous employee advising use of cocaine at the facility was received by the Cabarrus County Department of Social Services and the City of Concord Police were contacted.

On 3/2/05, an anonymous call was received alleging the supervisor in charge (SIC) was intoxicated and asleep at the facility. The Adult Protective Services Social Worker and Adult

Home Specialist visited the facility and found the SIC in the med room. Based on observation, the employee smelled of alcohol but was able to perform her duties. She was observed for an extended period of time during the visit.

On 3-11-05, during a facility survey being conducted by the Division of Facility Services and the Cabarrus County Department of Social Services, the Concord Police Department detained and questioned two residents for the use of illegal drugs at the facility.

On 7-4-05, the Police were called to the facility after an incident occurred involving a suspected drug dealer coming into the facility trying to collect drug money from a resident. Per interview with a facility staff person on 7-13-05 at 2:15 p.m. regarding the incident on 7-4-05, the resident had met an alleged drug dealer on the corner outside the facility and had come back into the facility on the pretense that he was to show someone else the drugs. He then yelled back to the drug dealer from the window that he would not come back out and he claimed the police had been called. The drug dealer then entered the facility and sat on the couch in the living room area and advised staff she would not leave without her $200.00 or "stuff". The resident had run out of the facility and staff advised the alleged drug dealer to leave since the staff had indeed called the Police once the drug dealer had come into the facility making demands. The alleged drug dealer then left and the employee went outside attempting to locate the resident or drugs. The Police came to the facility and searched the resident's room but no drugs were found. The alleged drug dealer called the facility back on 7-5-05 demanding payment for the drugs. The Police were again called to advise them of the phone call.

On 7-5-05, the police were called to the facility after a resident struck another resident during an argument that resulted in injury to the resident requiring stitches. On 7-6-05, visitors to the facility attacked a resident who was severely beaten requiring the resident to be taken to the hospital emergency room. The Concord City Police and E.M.S. were called to the facility regarding the incident. Such activity violated the rights of all facility residents and presented a serious threat to their safety and welfare.

An interview with a resident on 7-27-05 who has a diagnosis of paraplegia revealed that staff did not change him every 2 hours. The resident stated that on 7-25-05 he was put to bed at 4:30 p.m. and requested staff to change him at that time. He further stated that they did not return to change him until 8:30 p.m.

Based on record review and interviews with facility staff during the survey of 7/20/05 and the physician's office on 7-27-05, a resident was upgraded to skilled nursing level of care and an FL-2 completed reflecting that level of care dated 5-18-05. The facility had not noted the change and failed to clarify this level of care order with the physician. This failure placed the resident at great risk of serious harm and potential for not receiving the care and services needed.

At the 07/19/05, the interior corridor temperature measured 88 degrees F. Licensure rule 10A NCAC 13F .0311(c) requires that "Air conditioning or at least one fan per resident bedroom and living and dining areas shall be provided when the temperature in the main center corridor exceeds 80 degrees F (26.7 degrees C)." Several resident rooms did not have fans or air conditioning for residents. Failure to provide additional air movement for residents during extreme hot temperatures may jeopardize residents' health.

On 7-20, 21&22-05, the surveyors found the temperature in the facility to range from 84 to 92 degrees F. presenting a health risk to residents as well as staff. Although fans were operating and the air conditioning unit was running, the facility failed to take alternate and additional steps to

protect residents at risk. Surveyors measured the temperature on 7-20-05 at 7:45 am to be 84 degrees. At 2:10 p.m., the temperature was measured to be 92 degrees. On 7-21-05, surveyors again measured the temperature inside the facility to be 88 degrees at 9:00 a.m. At 10:30 a.m. the temperature measured 92 degrees. At 11:10 a.m., an air conditioning repairman came to the facility to perform maintenance on the air conditioning unit after being called by the facility. On 7-20-05 several residents were interviewed concerning the temperature in the facility. One resident was quoted as saying, " It's hot, too hot to sleep". Another resident said that he had gotten a living room box fan from his uncle's house and that he takes it to his room at night. One resident said, " It's warm, but OK". Another resident was quoted as saying, " The heat was intolerable for awhile". A resident who was transferred to another facility by the Cabarrus County Department of Social Services Adult Protective Services who was determined to be at risk for harm said, " I'm too hot to breathe, it's hot man, I don't feel safe, is there somewhere else I can go" ? The Cabarrus County Department of Social Services , after evaluating the potential for harm to residents due to the extreme temperature inside the facililty, determined during the survey that another resident needed to be removed from the facility to be protected from effects of the heat.

On 7/27/05 temperatures in the facility ranged from 84 to 92 degrees F. Temperatures in the rooms located on the end of the building up from the back door were measured to be 90 to 92 degrees F consistently. The temperature in the room of a resident who requires total assistance from staff for transfer and mobility measured 92 degrees F. at 12:20 AM, 90 degrees F. at 12:45 AM, 92 degrees F. at 10:45 AM and 92 degrees F. at 3:15 PM even though there were 2 fans in the room. The resident stated, “It’s too hot for anybody”. The staff was not observed to offer increased fluids, cool cloths or any measures to assist residents’ tolerance of the hot temperatures

2. G.S. 131D-21 Resident Rights (#1) and 10A NCAC 13F.0909
31D-21(2) Declaration of residents’ rights Each facility shall treat its residents in accordance with the provisions of this Article. Every resident shall have the following rights:

> **(1) To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.**

The facility failed to assure that residents are treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. On 7-20-05, the facility failed to pick up and return a resident from a medical appointment in a timely manner. The resident was made to wait approximately one to two hours during which repeated calls were made to the facility. According to interview, the delay in response was due to the transportation employee first picking up a family member (who also worked at the facility) from another location.

Based on interviews on 7-27-05 with two staff and one resident, residents who are dependent on care and services from staff were not spoken to with consideration and did not receive the care as needed or requested on a timely basis. Interviews revealed staff used harsh tones or foul language when speaking to residents and residents were told they had to wait for care.

Observation on 7/27/05 of incontinence care performed at different times in the facility revealed that there were no privacy screens provided for residents to shield them from view of their roommates. Observation of ten (10) rooms in the facility revealed no screens or curtains to provide the necessary privacy.

3. 10A NCAC 13F. 0305 Physical Environment

The facility failed to assure that all residents' bedrooms were equipped with insect screens. Based on observation and interview of management staff and Division of Facility surveyors during the 7-20,21& 22-05 survey, the facility failed to assure that the housekeeping closet containing hazardous materials, remained locked when not in use or supervised.

The facility failed to ensure that each exit door accessible by residents was equipped with a sounding device activated when the door was opened. Review of FL-2s revealed 3 residents who were identified as intermittently disoriented. The facility records and interviews with staff indicated that there were documented wanderers under the facility's care. The back door alarm failed to function when tested. Failure to have a working alarm at the rear door placed wandering residents in danger from elopement, thus exposing them to traffic, terrain, and other dangers and hazards. The door alarm systems were not working at the survey entrance at 12:30 a.m. on 7-27-05 when surveyors entered the building. Three doors were checked and none alarmed when surveyors opened them. One resident returned to the facility at approximately 12:45 a.m. and no alarm was noted. The facility was staffed with two aides. Without alarms activated, staff were unable to know of residents or visitors entering or leaving the facility unless they observed them.

Staff person accompanied surveyor to the door after stating that alarms worked and opened the back door. No alarm was noted. Staff person stated she thought they needed new batteries. The alarms remained non-functioning throughout the day on 7/27/05. Interview on 7/27/2005 with a resident revealed that both staff and residents turn off the alarms. The manager was notified of the problem, and stated she would get new batteries.

4. 10A NCAC 13F.0306 Housekeeping and Furnishings

The facility failed to maintain the building in an uncluttered, clean and orderly manner, free of all obstructions and hazards. On 7-20, 21&22-05, surveyors found broken mirrors in residents' bedrooms which presented a hazard, broken sinks in the bedrooms, broken windows in the dining rooms and bathroom, missing towel bars in some bedrooms or adjoining bathrooms and a fly problem throughout the building.

5. 10A NCAC 13F.0309 Plan for Evacuation

Based on observations and interviews on 7/20/05, the facility had no written fire evacuation plan and no diagrammed drawing posted in the facility. Based on interviews on 7/20/05, no fire drills had been conducted. There were no documented fire rehearsals available for review on 7/20/05. Based on interview on 7/20/05, there was no written disaster plan or documentation of contact with the local emergency management agency.

Based on interviews with staff and residents on 7-27-05, no fire drills had been done since staff with the Division of Facility Services and the Cabarrus County Department of Social Services had identified this problem during the survey on 7-20, 21 & 22-05. Based on interviews with facility staff on 7-27-05 and an inspector with the Construction Section of the Division of Facility Services on 7-22-05, facility staff was not knowledgeable of how to pull the alarm or reset the fire alarm.

In addition, the facility had one resident requiring the use of a Hoyer lift for transfer. The facility staffed two aides on second and third shift and it was confirmed through interview with 3 of 4 staff that only staff on the first shift had been trained on how to operate the Hoyer lift. Proper use

of a Hoyer lift requires 2 people to operate it safely and properly. The facility also had at least one other resident identified as needing assistance with transfer from bed to chair. This resident was also identified by staff as smoking in his bed. Based on interview with staff, supervision is provided when the cigarette is lit and when extinguished.

6. 10A NCAC 13F.0311 Other Requirements

The facility failed to maintain the building and all fire safety, electrical, mechanical, and plumbing equipment in a safe and operating condition.

Guttering was full of debris and in poor repair.

There were at minimum, 7 heat detectors (Kitchen, storage room, office, janitor closet, employee bathroom, hall bath, bedroom #room 2) that had been painted over, thus compromising their ability to react to a fire condition in a timely manner. There was one smoke detector in near the laundry that failed to activate the fire alarm system when tested.

At the time of survey, the interior corridor temperature measured 88 degrees F. Licensure rule 10A NCAC 13F .0311(c) requires that "Air conditioning or at least one fan per resident bedroom and living and dining areas shall be provided when the temperature in the main center corridor exceeds 80 degrees F (26.7 degrees C)." Several residents' rooms did not have fans or air conditioning for residents. Failure to provide additional air movement for residents during extreme hot temperatures may jeopardize residents' health.

The sink in the drug storage room failed to work when tested. Failure to have a working sink at the medication dispensing area reduces the likelihood that proper handwashing is performed by medication staff who administer medications to residents and may compromise aseptic conditions affecting resident's health.

There were spaces that no heat detectors were installed. Heat detectors or smoke detectors must be installed in all spaces in accordance with the 1971 licensing rules per current rule that must be installed in accordance with the requirements of the 1971 licensure requirements and rule.

The 1971 minimum standards require compliance with the 1971 applicable edition of the NC Building Code. Section 516.1(c)(1) of the 1967 Building Code requires that all spaces in this institutional building be equipped with, at minimum, fire (heat) detection devices, connected to sound the fire alarm system in the event of a fire in the protected space. And shall be maintained. Failure to have at least heat detection in each space could delay staff alerting of a fire emergency, thus reducing the minimum expected safety for residents

7. 10A NCAC 13F.0403 Qualifications of Medication Staff

The facility failed to assure that 3 of 7 sampled staff who were determined to administer medications had documentation of successfully completing the clinical skills validation portion of the competency evaluation or successfully passed the written examination according to Rule 10A NCAC 13F.0503. Based on documentation on the 07/05 medication administration record and interview with residents, the unqualified staff had administered medications to residents. Administration of medications by unqualified or untrained staff places residents at imminent risk.

8. 10A NCAC 13F.0504 Competency Validation for Licensed Health Professional Support Tasks

The facility failed to assure that non-licensed staff were competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) of Rule. 0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. No documentation of such competency validation was found for staff transferring and lifting a resident with a Hoyer lift, feeding residents with swallowing disorders and providing care to residents with restricted fluids.

Based on interviews conducted 7/27/05, the facility failed to ensure that all staff competency skills for use of the Hoyer lift had been validated. One resident in the facility was totally dependent on staff for transfer and mobility. The staff is to use the Hoyer Lift for transferring the resident from bed to chair and from chair to bed. Staff not being trained and having their competency validated by a licensed health professional increase the risk of accidents.

9. 10A NCAC 13F.0601 Management of Facilities with a Capacity or Census of Seven to Thirty Residents

The administrator failed to demonstrate responsibility for the total operation of the facility and be responsible to the licensing agency and monitoring agency for meeting and maintaining the rules of this Subchapter.

Based on interview by phone on 07/20/05 at 1:45pm, after the facility was asked to contact the administrator and notify her that a DFS/DSS survey was in progress, the administrator-in-charge responded "there's no way we can come down today, my mom (the administrator) has an appointment today at 2:15PM."Per interview of the Manager on 07/20/05 at 7:25PM, "I call (administrator-in-charge), I can get her by phone. She meets me halfway, but doesn't come to the facility." Per interview of the Manager on 07/20/05 at 7:10PM, when asked if she had been keeping in contact with the administrator "I've talked to (administrator-in-charge) several times, she says to call back if I need her." When asked if she felt capable of handling the current situation regarding the temperature readings of the facility and APS involvement, she responded "no", when asked if she had told her she needed her, she responded "no." Per interview of the Manager on 07/21/05 at 7:50 AM, "I called (administrator-in-charge) last night and told her that I needed her, she said to call her if I needed her." Per phone interview of administrator-in-charge with the surveyor on 07/21/05, when she was advised that there were problems with the facility and urged to come in "You do realize it's hot out there?" I've contacted someone and the air conditioner needs to be cleaned, the outside unit. It will be fixed today." When the administrator-in-charge was asked who was responsible for the hiring of staff "that would be me."

Based on interview during the 7/20/05 – 07/22/05 survey, two medication aides, both of whom had worked at the facility for over a year, stated they rarely saw the administrator or administrator-in-charge. One aide stated she had only seen the administrator-in-charge one time in the past year and the other "maybe five occasions".

Based on interview conducted on 7/27/05, 2 of 3 staff revealed they had last seen the administrator-in-charge in 01/05. The third one had seen her only once this year. Two of 3 residents had never seen her and the third resident had not seen her in a year. None of the staff or residents had seen the administrator. Interview with the administrator-in-charge on 7/27/05 revealed she had been in the facility last week before the survey team arrived.

10. 10A NCAC 13F.0703 Tuberculosis Test, Medical Examination and Immunizations

The facility failed to assure that upon admission, 2 of 6 residents sampled had been tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205, including subsequent amendments and editions. For one resident, the facility failed to acknowledge and clarify with the physician an FL-2 which reflected an upgrade in the level of care to skilled nursing in order to determine if the services of the facility could meet the resident's needs.

11. 10A NCAC 13F.0802 Resident Care Plan

The facility failed to assure, for two residents sampled, that a care plan was developed in conjunction with the resident assessment within 30 days following admission according to Rule 13F.0801 and that includes a statement of the care or service to be provided, frequency of service provision and signed and dated by the resident's physician.

12. 10A NCAC 13F. 0901 Personal Care and Supervision

The facility failed to assure that hand bells or other signaling devices were supplied, when indicated, to semi-ambulatory and non-ambulatory residents for their reasonable use. During the survey of 7-20, 21&22-05, one paraplegic resident was noted by surveyors to resort to yelling to gain assistance from facility staff. Observation on 7-26-05 confirmed that a resident identified by the surveyors on 7-20, 21&22-05 still had no access to hand bells or another signaling device.

It was noted as a concern on a monitoring report from a facility visit on 6/22/04 for the first time regarding resident #11 and the concern for safety was discussed with the Supervisor in Charge (SIC) who is no longer employed at the facility. The SIC stated the resident was not allowed to smoke in bed but the roommate would provide cigarettes and light them. Interview with residents who are bed bound or with limited mobility revealed that if they needed help they had to yell for help or care, as no call bells were available for use. Observation on 7/27/2005 confirmed that resident identified by surveyors on 7/20, 21 & 22/05 still have no access to hand bells or other signaling devices. Interview with one resident with limited mobility revealed that if he needed help he would transfer himself to his electric wheelchair and go out in the hall to get the staff. The staff was aware of the problem. The Adult Home Specialist (AHS) of the Cabarrus County Department of Social Services observed the resident alone in the room smoking during visits to the facility on 2/17/05 and 2/25/05 and it was noted on the monitoring reports. The safety concern was again discussed with the SIC and they were advised supervision must be provided. The SIC stated the licensee was aware of the problem with the residents smoking in the building since other residents would also smoke in their rooms or the dining room area. During a visit to the facility by the AHS on 7/13/05, the same resident was observed alone in his room smoking. An employee was advised and the resident was told to put out the cigarette. The supervision of smoking for a resident was previously cited on a Corrective Action Report 4/8/04.

Based on staff interviews conducted 7/27/05, the facility failed to provide supervision for one resident with no to limited mobility in the lower extremities and limited mobility in the upper extremities who is allowed to smoke in his bed. Three of 3 staff reported lighting the cigarette, putting the ashtray in reach and returning when the resident was finished to remove the ashtray. Only one of the three staff indicated that they stick close by the room to remove the ashtray when he is finished. Allowing this resident to smoke in bed created an enormous risk to the resident's safety.

Based on interview on 07/27/05, a resident with limited mobility revealed that if he needed help he would transfer himself to his electric wheelchair and go out in the hall to get the staff.

13. 10A NCAC 13F.0902 Health Care

The facility failed to assure documentation in the resident' record, for 5 of 7 resident files sampled, of facility contacts with the resident's physician, physician service or other licensed health professional regarding resident care when illnesses or accidents occurred, visits to the resident by the physician or other licensed health professionals, written procedures, treatments or orders or implementation of the procedures, treatments or orders.

14. 10A NCAC 13F.0903 Licensed Health Professional Support

The facility failed to assure the participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status,
care plan and care provided within the first 30 days of admission or within 30 days after the date a resident develops the need for the task and at least quarterly thereafter, including:

1. Performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of the Rule;
2. Evaluating the resident's progress to care being provided;
3. Recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
4. Documenting the activities in Subparagraphs (1) through (3) of the Paragraph.

Based on record review, resident and management staff interview, there was no documentation that residents received on-site review, evaluation and care planning for the task of feeding techniques for swallowing problems, for one resident on a pureed diet, one resident needing assessment and evaluation for ambulatory status, transfer status, finger stick blood sugar testing, one resident needing assistive devices for lifting and transferring, and one resident needing restricted fluids.

15. 10A NCAC 13F. 0904 Nutrition and Food Service

The facility failed to have, for 3 of 6 residents sampled, a matching therapeutic diet menu for all physician-ordered therapeutic diets for the guidance of the food service staff. In addition the facility failed to assure all residents were provided one cup (8) ounces of pasteurized milk at least twice a day and water served to each resident at each meal, in addition to other beverages. Based on observation during the survey on 7-21-05, the facility failed to assure all foods were protected from contamination in that the milk in the refrigerator had passed the date of expiration for five out of twelve gallons present.

16. 10A NCAC 13F.1001 referenced to 10A NCAC 13G.1001 Medication Administration Policies and Procedures

The facility failed to ensure the development and implementation of written policies and procedures for the ordering, receiving, storage, discontinuation, disposition and administration of medications, including the self-administration of medications. During the survey of 7-20, 21&22-05, facility staff and the Supervisor-in-Charge indicated that they were not aware of any

written policies and procedures for medication administration. Problems were noted in the areas of self-administration, storage,
labeling, documentation on the medication administration records, controlled drugs, pre-pouring and medication administration.

Medications were stored in unlocked areas accessible to residents. Procedures implemented for transcription of orders and medication administration were not safe practices; therefore, the residents were placed at risk of medication errors due to administration of medications from an unlabeled container for one resident, entries for medication orders onto the medication administration record were transcribed from medication labels instead of physician orders resulting in medication administration errors. Based on interview with medication staff on 07/27/05, there were no medication error reports. Medication errors identified during the survey on 07/20/05-07/22/05 had not been addressed with staff or documented. All medication staff employed at the facility was not licensed health professionals; therefore, policies and procedures are necessary to provide standards of practice and ensure safe administration practices.

17. 10A NCAC 13F.1001 referenced to 10A NCAC 13G.1004 Medication Administration

The facility failed to assure that staff administered medications, prescription and non-prescription, and treatments according to orders by a licensed prescribing practitioner, which are maintained in the resident's record. During the survey of 7-20,21&22-05 and based on observation, record review and interview with residents and staff, it was determined that the facility did not ensure that medications were administered as ordered to 6 of 15 residents during the medication pass and 3 of 6 residents from review of records. A medication error rate of 29% was evidenced by the observation of 9 errors out of 31 opportunities during the 4 PM and 5 PM medication pass on 7-20-05 and 8 AM medication pass on 7-21-05.

18. G.S. 131D-4.4 Adult Care Home Minimum Safety Requirements

The facility failed to ensure that the care, safety, and services necessary to enable the residents to attain and maintain the highest practicable level of physical, emotional, and social well-being were provided. Five of seven residents sampled during the 7-20, 21&22-05 survey had needs for health care coordination that were unmet.

Based on interview of Resident on 07/20/05, the resident had leg wounds, per interview of the medication aide, also qualified as a SIC, Home Health was responsible for the care, that Home Health had been contacted, but were waiting for orders. The medication aide was advised to contact the physician for orders. The resident had two Stage II Pressure Ulcers, observed by the surveyor on 07/21/05, which did not have a dressing on, and was wearing adult pull ups that were soiled with smearings of stool and urine. Pressure ulcers, if not treated appropriately, are susceptible to infection, and can lead to necrosis of tissue and bone. Per record review, Home Health narrative notes concerning the care of the wounds was documented on 07/16/05 with an "OK" per MD. The narrative note was shown to the medication aide and she reported that she would check on it. A MD appointment was made for 07/25/05 per interview with the medication aide on 07/22/05, the aide was advised to re-contact the physician concerning the needed care of the ulcers before the appointment.

Observations on 07/27/05 confirmed health care coordination needs for the resident continued to be unmet. The facility had not contacted the home health nurse or physician to clarify the order dated 7/16/2005 for wound care. Per interview with the resident, the home health nurse was the

only one changing the dressing. Based on staff interview, staff was not aware of any dressing changes in the facility. Interview revealed that staff was not monitoring the dressing to determine if the dressing needed to be changed, such as being soiled, when home health was not present in the facility.

Resident had documented attempts of suicidal gestures, and documentation that the facility had been contacted and informed. The resident was not on suicide precautions, nor was the staff members present on the day of survey aware of the resident's history until surveyor reviewed the record. Please note, the resident was admitted on 07/19/05, the staff was notified by surveyor on 07/20/05.

Based on observations and record review on 7/27/05, the facility failed to clarify a level of care recommendation and/or transfer a resident whose level of care had been upgraded to Skilled Nursing Facility on 5/18/05. Not transferring this resident to the appropriate level of care facility as recommended by the physician puts this resident at risk for not receiving the ordered and necessary care and treatments.

Based on resident and staff interview, 2 residents missed scheduled medical appointments on 7/27/05 due to the lack of transportation by the facility.